Find your account balance at www.flexamerica.com

Question? E-mail support@flexamerica.com

FlexAmerica

Grace Period Claim Form

-DO NOT USE A FAX COVER PAGE-

DATE: _____
OF PAGES: _____

Grace Period Claim Filing & Documentation Instructions

1) This form should only be used for submitting **grace period** claims. Please note that this is an optional benefit and must be offered by your employer. Please contact your employer to see if this option is available.

2) Please sign claim form, include your email address and provide complete documentation for requested information**. Faxed claims received on Tuesday, will be mailed on Thursday.**

3) This claim will be applied to your prior plan year balance first. The remaining balance will **not** be applied to your current plan year unless otherwise specified.

4) Attach an Explanation of Benefits (EOB) or itemized bill from the provider showing the provider name, expense description, date of service, amount paid and, if applicable, amount covered by insurance**. Credit card receipts, cancelled checks, and cash register receipts are only acceptable for over the counter items.**

5) Submit pharmacy receipts showing date of service, prescription (Rx) name and number and total amount.

Company Name

Check ONE **(REQUIRED)**:
- ☐ NEW claim
- ☐ Resubmitted claim
- ☐ Letter of Medical Necessity on file

Employee Name	Daytime Phone Number	Social Security Number

Street Address: _____ City _____ State _____ ZIP Code _____

Check here if this a new address: ☐ Email Address _____

Grace Period Claim Reimbursement

Please Note **Please confirm with your employer that this option is available. This claim form should ONLY be used when requesting payment from your prior plan year balance.**

FAX claims to 301-564-5192

❑ **Check here if any remaining amount is to be applied to the current plan year.**

Do not use this area to enter dependent day care claims.

Account Type (Healthcare) Grace Period Claim	Dates of Service (from / to)	Reimbursement Amount Requested	Provider Name	Type of Service or Prescription (Rx) Number	Apply remaining balance to the current plan year **Yes or No**
ENTER TOTAL:					

Dependent Care Spending Account Reimbursement

Use this space for dependent day care expenses only	Dependent Care Expense Total Amount		Provider's Signature (required if receipt is not provided)	Provider Tax ID or Social Security Number
	Date(s) of Service	Apply remaining balance to the current plan year ❑ **Yes** ❑ **No**	Provider's Address	Age of Dependent(s)

Employee Certification

I certify that these expenses for which reimbursement is claimed have been incurred by me and/or my eligible dependents and are not payable by any other plan and will not be deducted on my federal, state or local income tax returns.

Employee Signature (**REQUIRED**) **DATE**

Comments on your claims: